Family Nursing & Home Care

Standard Operating Procedures

Pressure ulcer prevention and management

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Document Profile

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Author(s)	*Gilly Glendewar TV CNS* *Tia Hall Operational lead Adult nursing services*
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Version Control / Changes Made

Date	Version	Summary of changes made

Contents

Introduction

This standard operating procedure (SOP) has been developed to support FNHC clinical staff and homecare staff to ensure a standardised approach for the provision of care to those people who have or may be at risk of developing pressure ulcers and to ensure consideration is given where there are potential Safeguarding concerns.

All clinical staff including NMC registrants, non-registrants and Allied Health Professionals (AHPs) registered healthcare professionals caring for patients/clients/young people within the care of FNHC services.

Pressure ulcers are a global concern. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day (NHS Improvement, 2018). In Jersey, our aim is to help prevent and reduce pressure ulcer development and associated complications. FNHC have worked with other health and care providers across the island to develop a framework that can be used across the Island by services that provide care to people who may be at risk of developing pressure ulcers. Island Wide Pressure Ulcer Prevention and Management framework

Pressure ulcers can develop and deteriorate quickly, particularly in people considered to be at high risk, for example neonates, people with frailty, limited mobility or diabetes, those who are nutritionally compromised or at end of life .A pressure ulcer is defined as localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear and/or friction). The damage can present as intact skin or an open injury and may be painful. (NHSI, 2018)

The SOP supports delivery of person centred, optimal care standards by FNHC to prevent pressure ulcers and guide measurement

The SOP supports compliance with Jersey Care commission standards for homecare https://carecommission.je/wp-content/uploads/2019/02/JCC-Care-Standards-Home-Care and also Healthcare Improvement Scotland (2020)

https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx

SOP 1 Prevention of pressure ulcers

Purpose

This SOP supports the principles of realistic medicine which recognises the importance and value of informed choice and ensuring that people are at the center of care decisions. https://www.realisticmedicine.scot/

In addition, it emphasizes the role of multidisciplinary working and coordinated care and support for people with, or at risk of developing, pressure ulcers.

Scope

All clients, patients, children and young people in the care of FNHC at risk of developing, or identified with, pressure ulcers regardless of age.

Core Requirements

Purpose-T is the agreed risk assessment tool to be utilised for all people in the care of FNHC. This will replace the current Waterlow risk assessment tool

For those staff able to access EMIS Purpose–T is a template on EMIS and must be completed at the first contact with the patient, client, child or young person. For staff unable to access EMIS, this should be completed as a hard copy and placed in the patient's supplementary record or hard copy record. (See Appendix 1)

Where completion of the Purpose–T is not possible during the initial contact then the reason for this and the plan to complete must be documented in the person's care record and discussed with the clinical coordinator/Registered manager.

Following completion of the Purpose-T a pathway will be indicated to inform practice and appropriate interventions for care planning.

Purpose-T should be reviewed according to the pathway and clinical judgement, especially if the patient, client, child or young person's clinical condition changes but as a minimum monthly.

Patients, clients and carers should be provided with the required education and understanding of pressure ulcer prevention so that they know to alert the care team to any changes in the person's health and wellbeing that may increase their likelihood of developing pressure ulcers. The information shared should be documented in the person's care plan/records and the person or their carer should be provided with the Pressure ulcer prevention leaflet. It is important to check the person's understanding of this information and that they know how to contact the service to raise a concern.

Where a client, patient, child or young person is unable to move or reposition independently or uses mobility aids, then a moving and handling risk assessment should be completed on their EMIS or hard copy record

Where aspects of the pathway are not followed, the rationale for this should be documented in the person's nursing record e.g. patient choice.

Where there are concerns about a person's concordance and they have capacity to make decisions about their health in relation to pressure ulcer prevention, then a concordance risk assessment should be completed with the person and placed on their EMIS or hard copy record.

Consideration should be given to the benefit of a care passport (Appendix 2) available on EMIS or hard copy to support joint care planning and concordance.

SOP 2 Identification of pressure ulcers

Purpose

This SOP will ensure that all FNHC clinical staff and homecare staff will use consistent, accurate terminology to describe and recognise pressure ulcers to support effective written and verbal communication, treatment and ongoing care.

Scope

All clients, patients, children and young people in the care of FNHC at risk of developing, or identified with, pressure ulcers regardless of age.

Core Requirements

Pressure ulcer categorisation is defined by NHSI (2019) (Appendix 3)

At each contact it is expected that skin integrity will be checked/discussed by the visiting professional.

The check/discussion needs to be informed by the patient's presenting condition, clinical judgement and level of risk. The level of risk is informed by the Purpose-T risk assessment. The appropriate pathway will inform ongoing clinical response.

Clinical judgment of a registered healthcare professional should support and inform level of risk and appropriate response. Non Registered staff are able to complete the Purpose-T but must discuss with registrant when within the Community Nursing, Rapid Response Reablement or Child and Family teams.

Home Care can complete the Purpose-T but should escalate and refer to the Community Nursing teams when they identify a person who is high risk or is presenting with non-blanching erythema or when further input is required for advice or care.

Where a patient /client /young person declines a skin inspection this should be clearly documented in their EMIS/hard copy records including details regarding the discussion surrounding risks. Capacity should be considered in respect of the patients/client /young person's understanding of the risks and their decision making.

Where there is persistent refusal to allow skin inspections this should be escalated and a plan agreed to manage risk. A multiple risk assessment should be completed, highlighting the concerns relating to concordance but other risk factors also, and to be discussed and completed with input from the patient/client/young person (Appendix 10).

Where there are paid care providers or the person is in a care setting, liaison with the care manager should include their responsibility in developing risk management care plans and escalating /referring concerns re skin integrity to FNHC

Where a care provider/care setting staff report no concerns with skin integrity the registered healthcare professional should use their clinical judgement to determine an appropriate approach to regular skin inspections. This should be detailed in the patient/clients/young person care plan.

All pressure ulcers including unstageable, suspected deep tissue injury (SDTI), category 1,2,3 and 4 should be reported on ASSURE.

Any deterioration of existing pressure ulcer should be reported on ASSURE.

SOP 3 Management of pressure ulcers

Purpose

This SOP will support a multi-disciplinary team (MDT) approach to managing risks and reducing deterioration of pressure ulcers.

Scope

All clients, patients, children and young people in the care of FNHC at risk of developing, or identified with, pressure ulcers regardless of age.

Core Requirements

The Purpose-T (appendix 1) pathway will guide the Registered health professional in developing the appropriate care for the patients/clients/young person

The Family Nursing & Home Care Wound Formulary (add in hyperlink as under review) informs wound care choices. The wound formulary should inform discussions with patients/clients/child/young persons about dressing choices and cost where these are funded by the person.

Patient choice should be respected when making recommendations about management and preventative interventions and these discussions should be recorded in the person's EMIS record. This includes equipment, dressings and positioning.

Where a patient/client/child/young person is end of life (red/amber GSF), consideration should be given to effective symptom management to support positioning and personal choice. These discussions and decision-making regarding risk should be clearly documented in the EMIS record.

Escalation to the Tissue Viability Clinical Nurse Specialist (TV CNS) should be undertaken if there is an unexpected deterioration in the wound or a lack of progress in healing, despite recommended interventions.

Consideration for conservative, surgical debridement or referral to the surgical team for more extensive debridement should be discussed with TV CNS (Appendix 9 in development).

Consideration for pressure mapping should be discussed with the TV CNS where there is a concern about surface seating.

FNHC are able to offer trial pressure redistribution cushions/mattress overlays for patient/client/young people to trail prior to purchasing.

Referral to an OT would be appropriate to assess and support with functional seating.

The GP should be informed in writing about any ongoing concerns regarding pressure ulcer management or deterioration to Category 3/4 pressure ulcers.

Where wounds continue to deteriorate or fail to heal then an MDT meeting with the GP, other professionals including care managers should be coordinated to manage risks and support best practice.

Where it is thought that the current package of care or placement is no longer meeting the patient/client/young person needs then escalation to social work for an urgent review should be undertaken via SPOR.

SOP 4 Pressure ulcers incident/statutory reporting

Purpose

This SOP will ensure compliance with the Jersey Care Commission (JCC) Home Care Standards Notifiable Events. Any incident that has or may pose a risk of harm a care receiver

Scope

All clients, patients, children and young people in the care of FNHC at risk of developing, or identified with, pressure ulcers regardless of age receiving care within a Regulated Service

Core Requirements

All pressure ulcers including unstageable, SDTI, category 1, 2, 3 and 4 should be reported on ASSURE.

Any deterioration of existing pressure ulcer should be reported on ASSURE.

Regulation 21 of the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 requires that a Registered Manager must notify the Jersey Care Commission of such accidents or other events that have posed or may pose a risk of harm to care receivers

All pressure ulcers category 2, 3, 4, SDTI or unstageable occurring in the care of FNHC should be notified to the JCC by the Registered Manager or delegate within 2 working days using the JCC notification of incidents form (Appendix 7) and sending securely via EGRESS.

Learning from incidents will be actioned and monitored where appropriate to help prevent a similar situation from occurring, as per Learning Events Investigation SOP (Appendix 8).

SOP 5 Pressure ulcers and safeguarding

Purpose

This SOP will support FNHC staff to l consider if any risks or incidents associated with pressure ulcers are a safeguarding issue in respect of making safeguarding personal and risk of harm.

Scope

All clients, patients, children and young people in the care of FNHC at risk of developing, or identified with, pressure ulcers regardless of age.

Core Requirements

When managing pressure ulcers, it is important to determine the patient/clients/young person view on the risks and development of the pressure ulcers.

Adults and children's pressure ulcer decision pathways differ (Appendix 4 and 5)

Making safeguarding personal principles should apply when considering the next steps:

- **Empowerment**
- **Prevention**
- **Proportionality**
- **Protection**
- **Partnership**
- **Accountability**

Where there are concerns about the risk to the individual or others then these should be discussed with the safeguarding lead/operational lead /team leader.

Consideration for next steps should be informed by Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry 2018 https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol.

The Adult Safeguarding Decision Tool should be completed by the Registrant/Team leader and discussed with safeguarding lead/operational lead /team leader (Appendix 6)

Record keeping should reflect all decision-making and concerns.

SOP 6 Education, training and competencies

Purpose

FNHC expects all clinical staff to develop and maintain skills, knowledge and competence in reducing the risk and managing pressure ulcers.

Scope

All clinical staff including NMC registrants, non-registrants and Allied Health Professionals (AHPs) and registered healthcare professionals caring for patients/clients/young people within the care of FNHC services.

Core Requirements

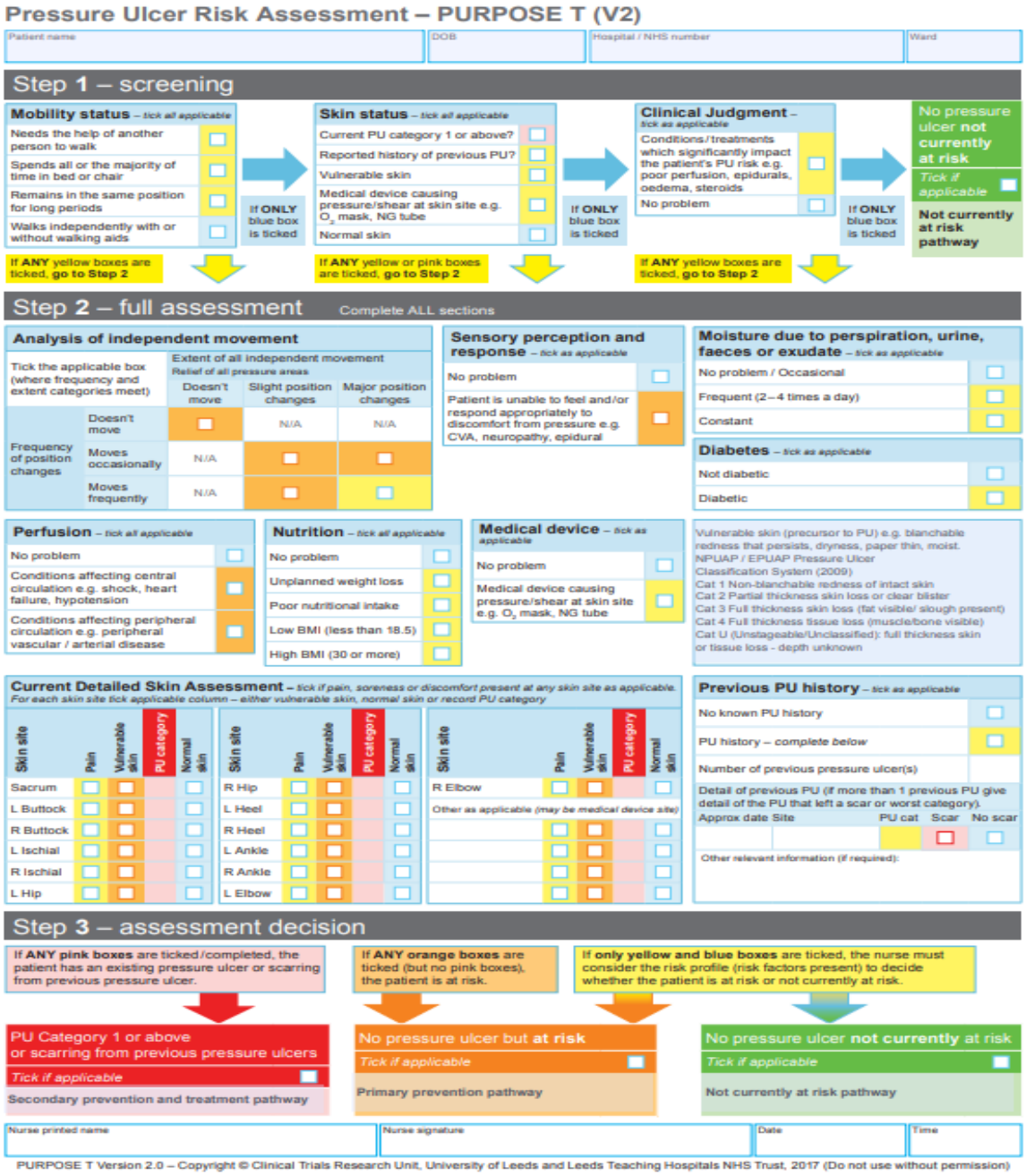
Ensuring staff are competent and confident to deliver safe and high quality care will ensure that the standards for education, training and information as described in Health Care Improvement Scotland (2019) are met.

https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pressure_ulcer_standards.aspx

The NHSI Core Curriculum (2018) should be used to guide content of training.

FNHC training can be found in FNHC education and development prospectus L:\FNHC\Central Filing\Education & Training

Appendix 1: Pressure Ulcer Risk Assessment



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Patient name | DOB | Hospital / NHS number | Ward

Step 1 – screening

Mobility status – *tick all applicable*
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If **ONLY** blue box is ticked

Skin status – *tick all applicable*
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If **ONLY** blue box is ticked

Clinical Judgment – *tick as applicable*
- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If **ONLY** blue box is ticked

No pressure ulcer **not currently at risk**
Tick if applicable

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*
- No problem / Occasional
- Frequent (2 – 4 times a day)
- Constant

Diabetes – *tick as applicable*
- Not diabetic
- Diabetic

Perfusion – *tick all applicable*
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – *tick all applicable*
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – *tick as applicable*
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category*

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable (may be medical device site)				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Previous PU history – *tick as applicable*
- No known PU history
- PU history – *complete below*
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable ☐
Secondary prevention and treatment pathway

No pressure ulcer but **at risk**
Tick if applicable ☐
Primary prevention pathway

No pressure ulcer **not currently** at risk
Tick if applicable ☐
Not currently at risk pathway

Nurse printed name | Nurse signature | Date | Time

Appendix 2: Care Support Agreement

CARE SUPPORT AGREEMENT blank.pdf

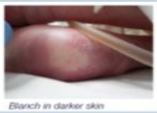
Repair hyperlink

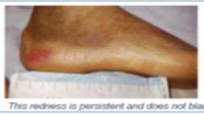
Appendix 3: Pressure ulcer categorisation

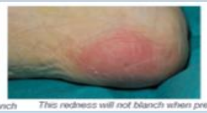
Pressure ulcer categorisation

Blanching erythema
Healthy skin may develop transient redness when subjected to pressure – for example, if the legs are crossed. To test if damage has occurred, light finger pressure should be applied to see if the skin blanches (goes white). In darker skin tones, redness may present as a darker area that is grey or purplish. This is **not** a pressure ulcer.


Example of skin blanch


Blanch in darker skin

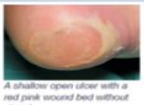

This redness is persistent and does not blanch

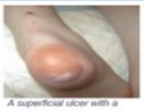

This redness will not blanch when pressure is applied

Category 1: Non-blanchable erythema
Intact skin with non-blanchable redness of a localised area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

Category 2: Partial thickness skin loss
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.* This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
**Bruising indicates suspected deep tissue injury.*


An intact serum-filled blister


A shallow open ulcer with a red pink wound bed without slough


A superficial ulcer with a collapsed blister


Full thickness tissue loss. Subcutaneous fat is visible but no bone, tendon or muscle

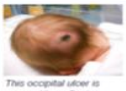
Category 3: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

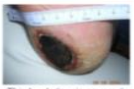
May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

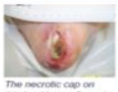
Category 4: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (eg fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

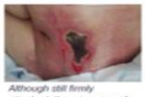

In this wound, the bone is clearly visible


This wound shows exposed muscle


This occipital ulcer is covered by softening necrosis


This heel ulcer is covered by hard dry eschar

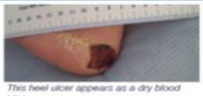

The necrotic cap on this heel has softened and started to separate

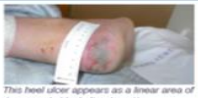

Although still firmly attached, there is a ring of demarcation where this eschar has been rehydrated

Unstageable: depth unknown
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.

Suspected deep tissue injury: depth unknown
Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.


This heel ulcer appears as a dry blood blister


This heel ulcer appears as a linear area of deep purple black discolouration

These images have kindly been supplied by members of the NHS Improvement pressure ulcer categorisation group. Permission has been given by the patients for them to be freely reproduced.
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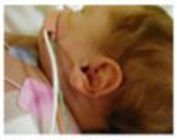
NHS England and NHS Improvement

Pressure ulcer categorisation

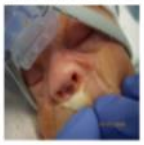
Device-related pressure ulcers (DRPU)

'Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes.'

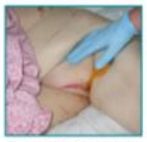
While some DRPU may also be allocated a category of damage, others may not as they are on parts of the anatomy that do not have the same structures as the skin – for example, the mucosal membrane. Where possible, a device-related ulcer should be categorised and the presence of a device noted by the addition of a (d) after the category.



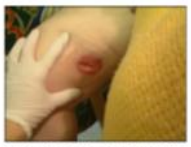
This infant has Category 1 damage to the cheeks and a small unstageable ulcer on the ear



This neonate has damage to the nares that cannot be categorised

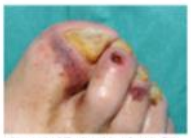


The damage caused by this urinary catheter could be categorised as a DTI (d)



Although difficult to identify, this PU was caused by the leather ring at the top of an old-fashioned calliper

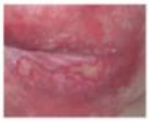
Damage has occurred where the spectacles and elastic from the oxygen mask press on the pinna of the ear



Although difficult to identify, this PU was caused by the patient having their feet caught in the bed sheets which were tightly twisted across the toes

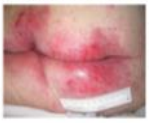
Moisture-associated skin damage

This can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat

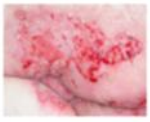


These multiple superficial lesions with diverse edges are typical of Incontinence Associated Dermatitis

The white cobblestone appearance of the tissue around this wound show evidence of significant maceration due to wound exudate remaining on the skin

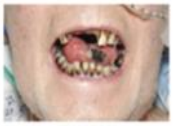


Wounds related to IAD such as these are often extremely painful



This wound demonstrates how the epidermis can easily be stripped away by incontinence

Mucosal pressure ulcers



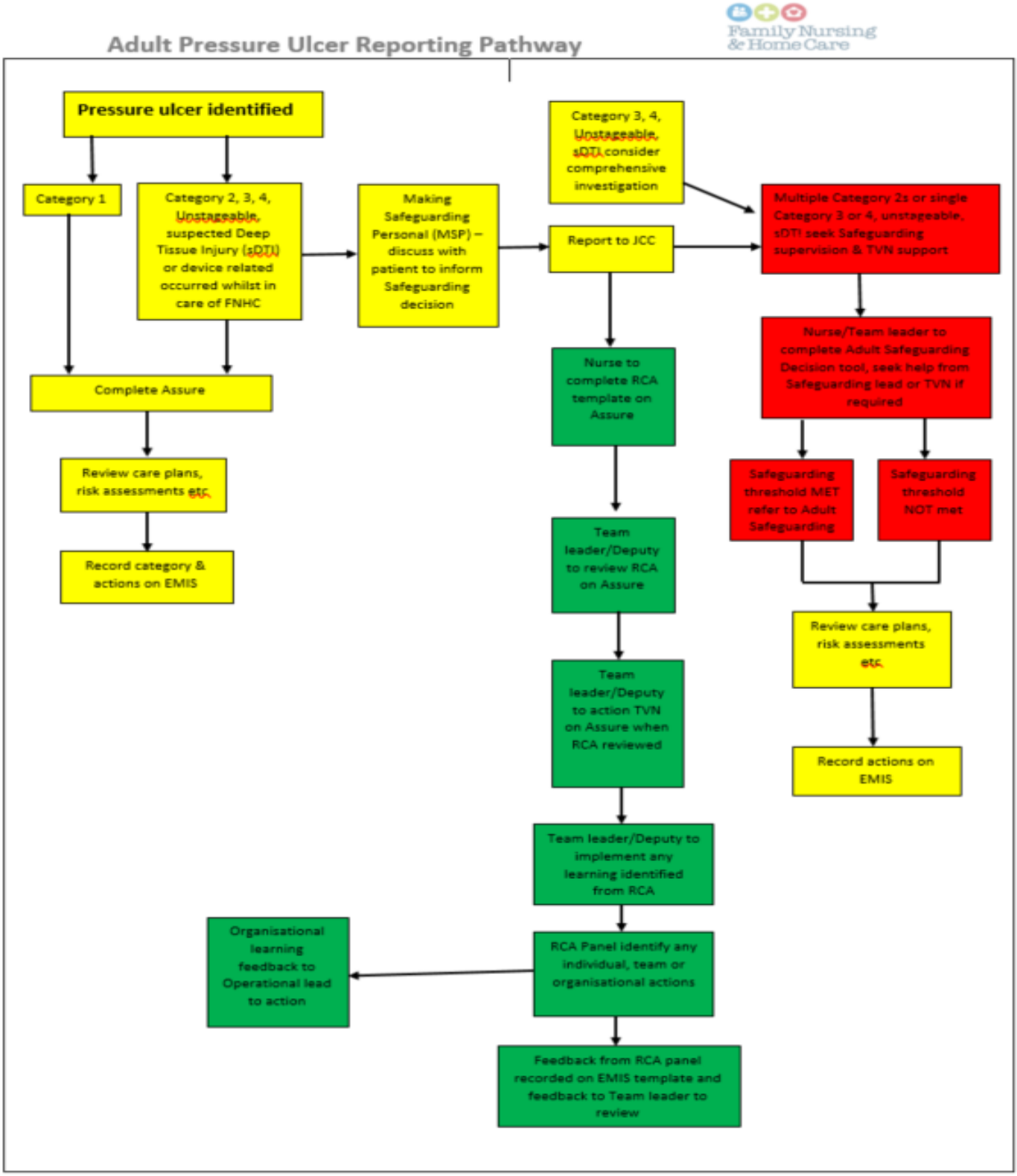
Mucosal pressure ulcers can not be categorised as the tissue does not have the same layers as the skin and therefore does not conform to the definitions. These PU are therefore uncategorisable (NOT unstageable) . They are usually caused by devices and therefore should be recorded as PU (d), locally you may wish to denote them as "Mucosal" or "Uncategorisable".

These images have kindly been supplied by members of the NHS Improvement pressure ulcer categorisation group. Permission has been given by the patients for them to be freely reproduced.

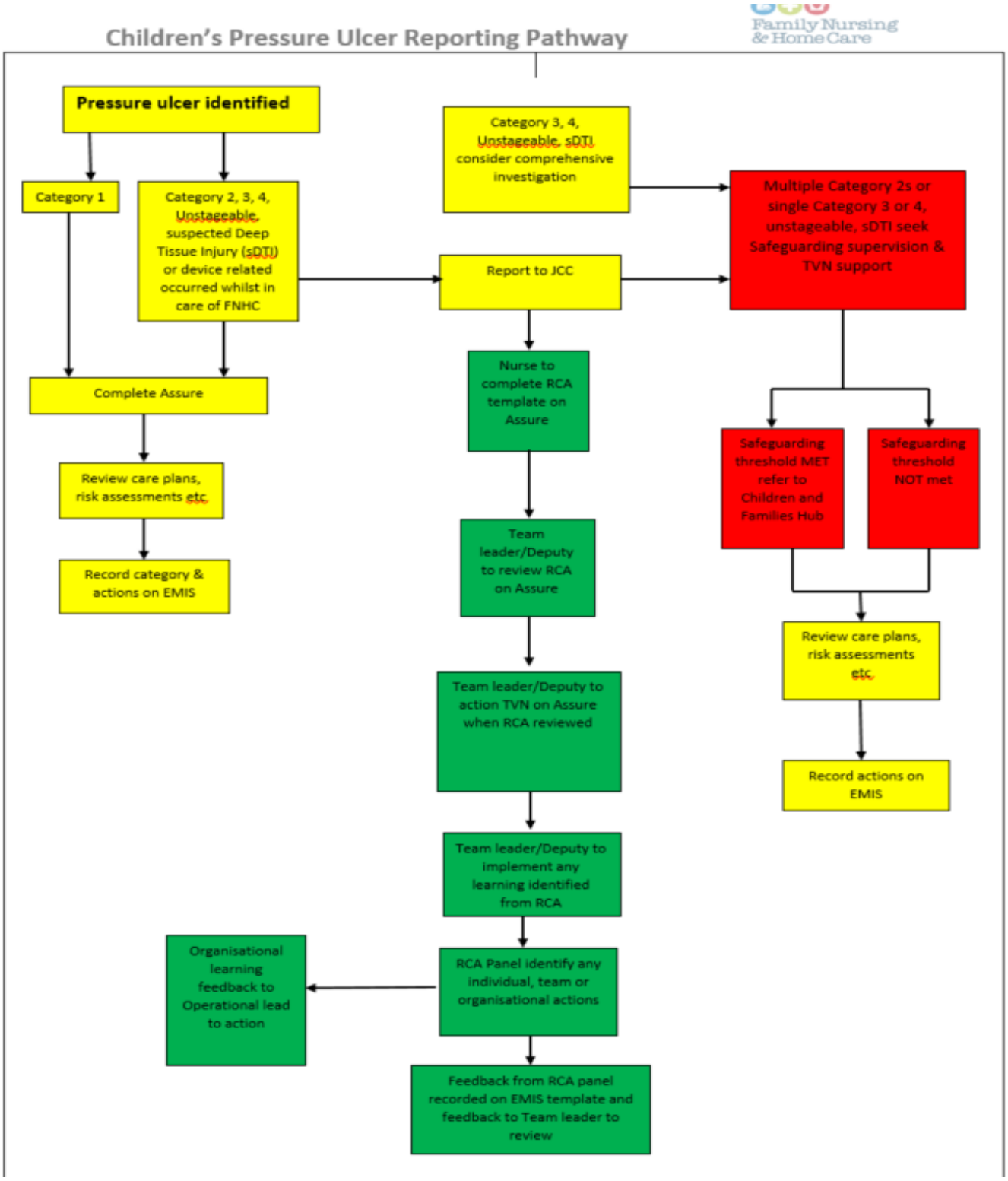
To cite this poster please use: NHS Improvement Pressure ulcer categorisation group (2019) Pressure Ulcer Categorisation. Available from http://nhs.stopthepressure.co.uk/

Publishing approvals reference 001103

Appendix 4: Adult Pressure Ulcer Reporting Pathway



Appendix 5: Children's Pressure Ulcer Reporting Pathway



Appendix 6: Adult Safeguarding decision tool DoH booklet

Adult safeguarding decision tool DoH booklet.pdf

Name
D.O.B:
EMIS .....
Or Affix Patient Label

Name of assessing nurse (PRINT)		Date	
Job Title		Signature	
Job Title		Signature	

Scoring sheet Adult Safeguarding Decision Guide for individuals with severe pressure ulcers

Q	Risk Category	Level of Concern	Score	Evidence examples	Actual score given	Additional and supporting information
Q 1	Has the patient's skin deteriorated to either grade 3/4/ unstageable or multiple grade 2 from healthy unbroken skin since the last opportunity to assess/ visit	Yes e.g. record of blanching / non- blanching erythema grade 2 progressing to grade or more	5	E.g. evidence of redness or skin breaks with no evidence of provision of repositioning or pressure relieving devices provided		
		No e.g. no previous skin integrity issues or no previous contact health or social care services	0			

Q2	Risk category Has there been a recent change, i.e. within days or hours, in their / clinical condition that could have contributed to skin damage? e.g. infection, pyrexia, anemia, end of life care, critical illness	Level of concern Change in condition contributing to skin damage	Score 0	Evidence example	Actual score given	Additional and supporting information
		No change in condition that could contribute to skin damage	5			
Q 3	Was there a pressure ulcer risk assessment or reassessment with appropriate pressure ulcer care plan in place and documented? In line with each organisations policy and guidance	Current risk assessment and care plan carried out by a health care professional and documented appropriate to patients needs	0	State date of assessment Risk tool used Score / Risk level		
		Risk assessment carried out and care plan in place documented but not reviewed as person's needs have changed	5	What elements of care plan are in place		
		No or incomplete risk assessment and/or care plan carried out	15	What elements would have been expected to be in place but were not		

Q 4	Is there a concern that the Pressure Ulcer developed as a result of the informal carer willfully ignoring or preventing access to care or services	No / Not applicable	0			
		Yes	15			
Q 5	Is the level of damage to skin inconsistent with the patient's risk status for pressure ulcer development? e.g. low risk–Category/ grade 3 or 4 pressure ulcer	Skin damage less severe than patient's risk assessment suggests is proportional	0			
		Skin damage more severe than patient's risk assessment suggests is proportional	10			

	Risk category	Level of concern	Score	Evidence examples	Actual score given	Additional and supporting information
6	Answer (a) if your patient has capacity to consent to every element of the care plan. Answer (b) if your patient has been assessed as not having capacity to consent to any of the care plan or some capacity to consent to some but not the entire care plan.					
a	Was the patient compliant with the care plan having received information regarding the risks of non-compliance?	Patient has not followed care plan and local non concordance policies have been followed.	0			
		Patient followed some aspects of care plan but not all	3			
		Patient followed care plan or not given information to enable them to make an informed choice.	5			

	Risk category	Level of concern	Score	Evidence examples	Actual score given	Additional and supporting information
b	Was appropriate care undertaken in the patient's best interests, following the best interests' checklist in the Mental Capacity Act Code of Practice? (supported by documentation, e.g. capacity and best interest statements and record of care delivered)	Documentation of care being undertaken in patient's best interests	0			
		No documentation of care being undertaken in patient's best interests	10			
		TOTAL SCORE				

If the score is 15 or over, discuss with the local authority (safeguarding) as determined by local procedures and reflecting the urgency of the situation. When the decision guide has been completed, even when there is no indication that a safeguarding alert needs to be raised the tool should be stored in the patient's notes.

Appendix 7: JCC notification form

Notification of Incident Form

Regulation 21: Notification of incidents, accidents and other events.
Please complete the form below and email to: notifications@carecommission.je within 2 working days of the incident.

Information about the Registered Care Service			
Registered Provider:	Registered Manager:	Location of incident:	
Information about the person(s) affected by the incident			
Name:	Address:	Telephone: Email:	
Care receiver ☐	Care/support worker ☐	Volunteer ☐	Other (please state) ☐
Information about the incident			
Date of incident:	Time of incident:	Location of incident:	
Description of the incident:			
Were there any witnesses to the incident? If yes provide names and contact details:			
Was the person injured? If so describe the injury:			
Was medical treatment provided? Please state where and who by:			
Has any action been taken following incident: (if an investigation is taking place, please state so and send report when complete)			
Name and role of person submitting notification:			
Signature:	Date completed:		

Appendix 8: Learning Events Investigation SOP

investigations-sop-learning-events-final-9421.pdf (fnhc.org.je)

Appendix 9: Debridement SOP in development

Appendix 10: Multiple Risk Assessment form

Multiple Risk Assessment Form

MICKEY, Mouse (Mr)
01-Dec-2012
27532

Current Situation:

Sheet Number:

Risk Number	Description of risk (to self and others)	Does patient/client understand the implications?	Benefits associated with taking the risk	What can be done to reduce risk?	Action to be taken

Multiple Risk Assessment Form

Risk Number	Description of risk (to self and others)	Does patient/client understand the implications?	Benefits associated with taking the risk	What can be done to reduce risk?	Action to be taken

Signature of Assessor: ..... **Client's Signature:** .....

Date & Time: ..... **Reassessment Due:** .....